DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FOR QUESTIONS CALL: 1-800-999-1118

MEDICARE QUESTIONNAIRE FOR DISABLED BENEFICIARIES

NAME	DATE OF BIRTH	MEDICARE NUMBER
MARY SMITH	5/10/54	123456789A

INSTRUCTIONS: This information will be read by a computer. Please print as shown below. Stay within the boxes. Use CAPITAL letters. Mark boxes with an X. USE BLACK OR BLUE INK.

EXAMPLE [ ][A][B][C][ ][1][2][3][ ][ ][ ]

SECTION A - INFORMATION ABOUT YOU

1) Are you getting any group health coverage from an employer for whom you **now** work (full or part-time)?

YES [X] NO [ ] **(If NO, STOP, complete Sections B & C)**

2) How many employees, including yourself, work for the employer from whom you get group health benefits?

Don't Know [ ] 100 or more [X] Less than 100 [ ] (If less than 100, **STOP**, go to Section B)

3) What type of coverage do you have under your employer's health plan?

Worker only coverage [ ] Family coverage (husband/wife, other family member) [X]

Please print the name of the employer, and information about the employer group health plan in the spaces below:

EMPLOYER NAME
ACME DYNAMITE CO

ADDRESS
345 FARAWAY STREET

CITY: SATURN STATE: ME ZIP: 55555

NAME OF GROUP HEALTH PLAN
GOOD HEALTH INC

ADDRESS
789 THIRD AVENUE

ADDRESS
SUITE 16

CITY: MARS STATE: ME ZIP: 66666

GROUP IDENTIFICATION NUMBER

POLICY NUMBER

SECTION B - MORE INFORMATION ABOUT YOU

1) Are **YOU** getting Black Lung (Coal Miner's) Medical Benefits?

YES [ ] NO [X] If **YES,** Date Benefits Began: [ ][ ] – [ ][ ] – [ ][ ][ ][ ] (M M – D D – Y Y Y Y)

2) Are **YOU** now getting any medical services, related to an illness or injury which occurred on the job, for which **YOU** have or will file a workers' compensation claim?

YES [X] NO [ ] If **YES,** Date of Illness or Injury: 04 – 20 – 2000 (M M – D D – Y Y Y Y)

If **YES,** Insurer Name
EMPLOYERS ACCIDENT FUND

ADDRESS
211 MAIN STREET

ADDRESS

CITY: BREEZY STATE: ME ZIP: 66661

OMB NO. 0938-0214

SAMPLE

(TURN PAGE OVER)